Issues for
Michigan's Children

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Closing the Gap: Addressing Racial and Ethnic Health Disparities Among Michigan's Children

The health of Michigan's children has improved over the last decade.

Over the last decade, the health of Michigan's children has improved in many significant ways. Infant mortality fell by 23 percent, child deaths declined by 29 percent, birth to teens fell by nearly 40 percent, access to adequate prenatal care improved, and teen violent deaths–by accident, homicide or suicide–dropped by more than one-third. Overall, children have benefitted from public health improvements, advances in medical technology and treatment, and expansions of publicly-funded health insurance programs.

Despite overall improvements in child health, the gap between children of color and white children remains essentially the same.

Despite advances in health care, a closer look shows that not all children have benefitted equally, and dramatic health disparities continue to exist for children based on income, race and ethnicity. Compared with white children, African American and Hispanic children are more likely to be uninsured, to experience inadequate access to health care, and to be in poor health. For example, in Michigan, African American babies are more likely to have mothers that received late or no prenatal care, are two times more likely to be born at low birthweight, and are almost three times more like to die during the first year of life.

As they grow, children of color are more likely to suffer from treatable, and often preventable, illnesses and chronic diseases including asthma, diabetes and obesity. In addition, they are at much greater risk of violent death, with homicide still the leading cause of death for African American teenage boys and young adults.

The causes of health disparities are numerous, and not fully understood. While some differences disappear when children of color have the same access to health insurance and live in families with comparable income, other racial disparities appear to persist on the basis of race alone. The factors affecting health include:

- environmental, structural and institutional factors such as poverty, health care policies, residential segregation, exposure to environmental hazards, health care provider and specialist scarcities, and diminished access to medical care;
- provider factors such as a lack of cultural competency or diversity in the health care workforce; and
- patient factors such as cultural beliefs, mistrust of the health care system, lack of understanding of the importance of preventive care, personal life-style choices, genetics and language barriers.[1]

Health disparities are an increasing threat to the state's children, families and economy.

The children of Michigan, like those in many other states, are becoming increasingly diverse. In the last decade, the share of young children (ages 0 to 4) in Michigan that is from a racial or ethnic minority group increased over 50 percent, from 21 percent to 32 percent. As children of color become a growing part of Michigan's

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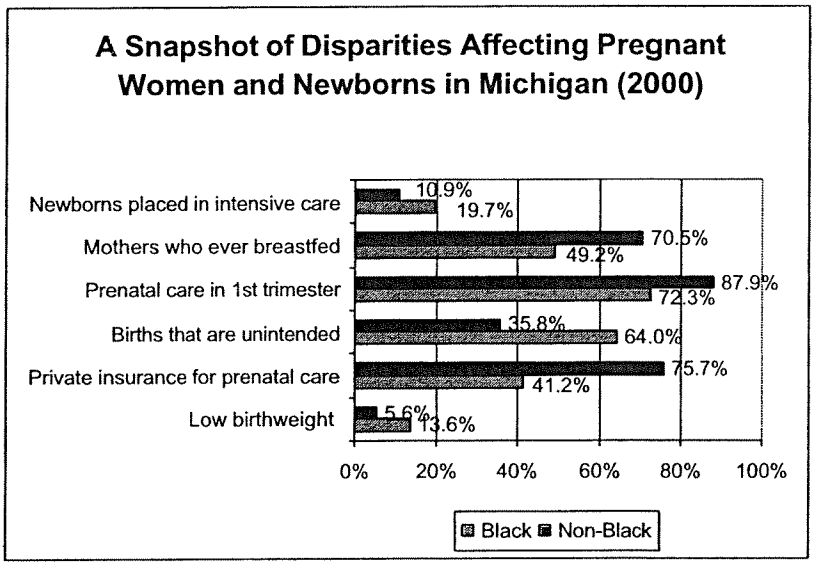
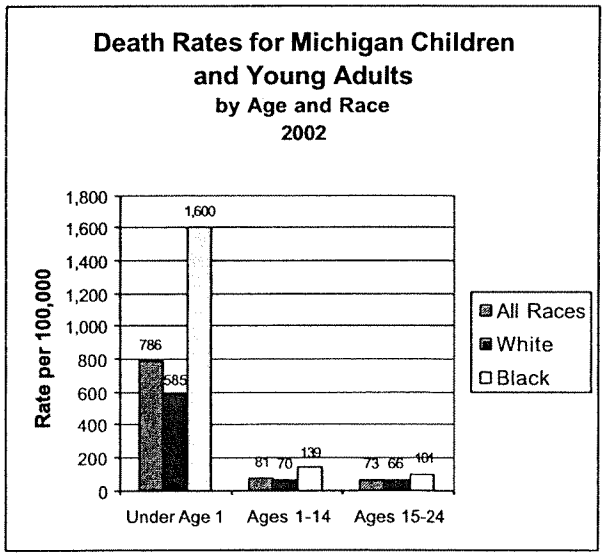
future, it is imperative that their health needs become the focus of a public dialogue and urgent action. A failure to address the health issues facing children from racial and ethnic minorities will have long-term repercussions for Michigan's future families, its work force and its economy.



A snapshot of health disparities for the children of Michigan:

Beginning at birth:

- While African American teens led the decline in teen parenting over the last decade in Michigan, they are twice as likely as white teenagers to become parents before the age of 20. Birth rates are also high for Hispanic and American Indian teenagers. Teenage mothers are more likely to give birth to babies that are low-weight, and that die before they reach the age of one.
- African American babies are three times more likely to be born to a mother who received late or no prenatal care. Nearly 8 percent of African American mothers receive no prenatal care or care that is delayed into the second trimester of pregnancy, as compared to 5 percent of Hispanic mothers, and 2 percent of white mothers. And, after some decline through the mid-1990s, the percent of births to women with inadequate prenatal care is rising. Overall, one in four African American mothers in Michigan reports that she was unable to receive prenatal care as early as desired, compared to only 16 percent of other mothers.[2]
- While maternal deaths are now quite rare, Michigan's ratio of black to white maternal deaths is one of the largest in the nation.[3]
- African American mothers in Michigan are more than three times more likely to receive their prenatal care in hospitals or clinics. Forty-one percent of African American mothers receive their care in hospitals or clinics, compared to only 12 percent of other mothers. Less than half receive care in a doctor's office or Health Maintenance Organization (HMO), compared to over 80 percent of other mothers.[4]
- African American babies are more likely to be born pre-term than other babies in Michigan, and are 80 percent more likely to be placed in neonatal intensive care.[5]
- African American babies are much more likely than any other racial or ethnic group to be born

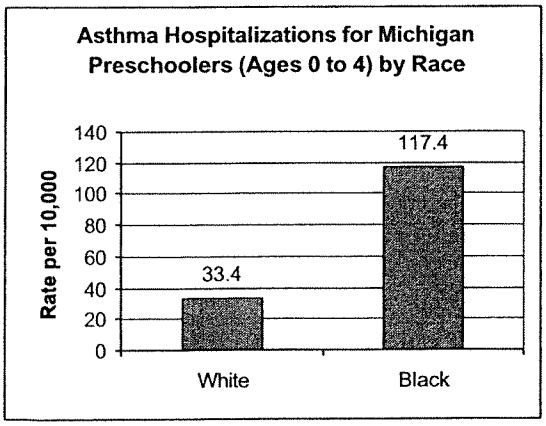


low-weight, and are therefore more likely to die in the early days and weeks of life, or to suffer developmental delays or lifelong chronic illnesses. Unfortunately, the incidence of low birth-weight is increasing. In 2001, African American babies in Michigan were the most likely to be born low-weight (14.2%), compared to white (6.7%), American Indian (8.3%) and Asian (7.7%) infants.[6]

- African American infants are much more likely to be born to HIV-infected mothers. In 2003, 49 infants were born to HIV-infected mothers in Michigan; 35 were African American.[7]
- The death rate from Sudden Infant Death (SIDS) continues to be two to three times greater for African American and American Indian infants than white infants, with some of those deaths attributed to higher bed-sharing, or nonstandard sleep surfaces such as mattresses on the floor or sofas.[8] SIDS rates have been falling in part because of the discovery of the importance of placing babies to sleep on their backs. Unfortunately, African American women have historically been nearly two times less likely to choose that sleeping position for their babies.[9]

During childhood:

- While asthma rates have been climbing nationwide, African American children are disproportionately affected, and are more likely to be unnecessarily hospitalized because of ineffective preventive asthma treatment. African American children in Michigan are four times more likely to be hospitalized for asthma complications, with preschool age African American males having the highest hospitalization rates. Further, African American children of school-age (ages 5 to 14) in Michigan are almost ten times more likely to die of asthma complications.[10]



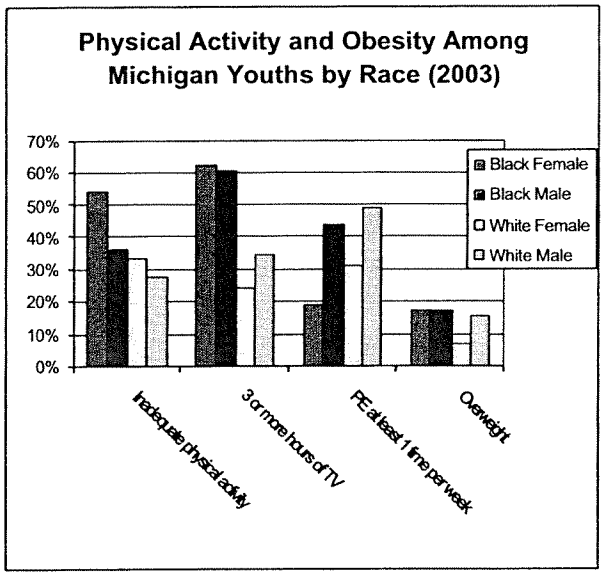
- African American children are less likely to receive needed dental care. One study showed that half (49.2%) of all white children visited a dentist annually, compared to less than one-third of black and Hispanic children (27.2% and 29.2 percent respectively).[11]
- Children of color are less likely to see an eye specialist or get lenses to correct their vision. In one study, white children enrolled in Medicaid were 37 percent more likely than minority children to receive eye care. African American and Hispanic children without health insurance fared far worse.[12]
- Children of color and low-income children are more frequently exposed to environmental hazards, including lead and hazardous waste. One national study showed that in central areas of large cities, 37 percent of African American, and 17 percent of Hispanic children had unacceptably high lead levels, compared to only 6 percent of white, non-Hispanic children.[13]
- Children of color in Michigan are more likely to suffer from a disability. The highest disability rates are found among American Indian children (11%), but African American (8%), Hispanic (7%) and multiracial children (9%) were also more likely to be disabled than their white peers.[14]
- African American youths are more likely to contract AIDS. In 2002, there were an estimated 147 Michigan children ages 0 to 12 living with HIV or AIDS. Three of every 4 young children with HIV/AIDS were African American.[15]

During adolescence:

- Adolescents are more likely to be uninsured than other children. In 2001, 8.1 percent of all Michigan children under the age of 18 were uninsured,

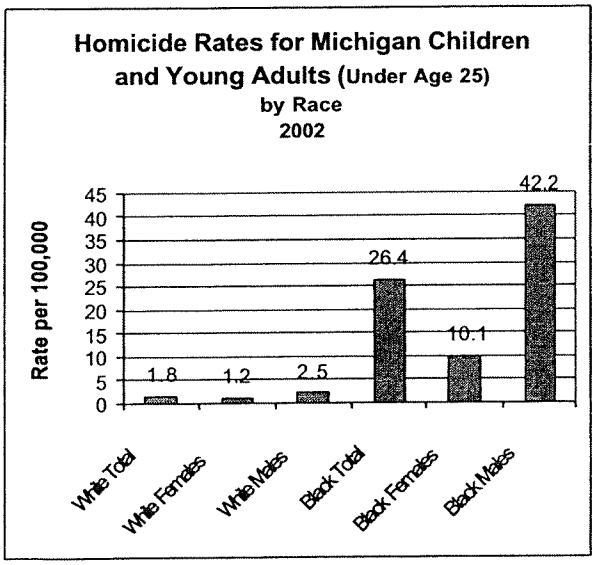
including more than one of every ten (10.4%) of youths between the ages of 13 and 17.[16]

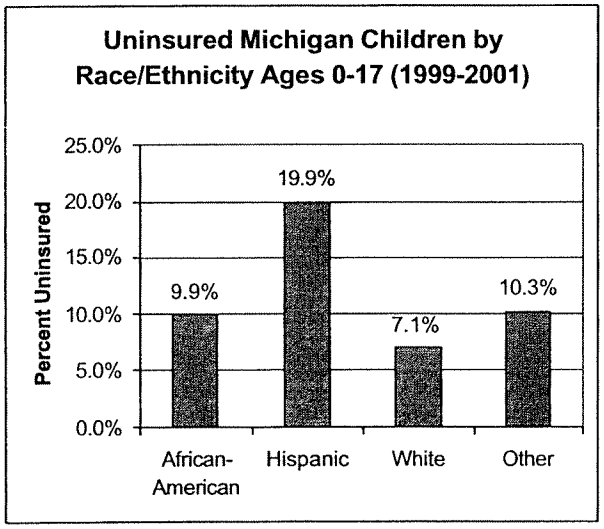
- Adolescents are less likely than adults to seek and receive basic preventive health care, even if they are insured. In Michigan, one in three adolescents report that they had not seen a doctor or health care provider for a preventive checkup or physical exam during the past 12 months–unless they were sick or injured.[17]
- African American youths and young adults in Michigan are 15 times more likely to be the victims of homicide than their white peers, with homicide still the leading cause of death of male African American adolescents and young adults.[18]
- One of every four Michigan children and youths are at risk for health problems because they are overweight. African American and Hispanic youths are at higher risk, and tend to be less vigorously active.[19] Nearly 45 percent of African American high school students in Michigan do not participate in sufficient physical activity, compared to 31 percent of white students. African American high school students are twice as likely to have participated in no moderate or vigorous physical activity, and were two times more likely to watch three or more hours of television in an average school day (61 percent for African American students, compared to 29.6 percent for white students).[20]



Children of color are less likely to have access to health care.

Children of color are more likely to be uninsured. Children of color in Michigan are significantly more likely to be uninsured, with Hispanic children least likely to have health insurance. Twenty percent of the state's Hispanic children are uninsured, compared to 10 per-





cent of African American children, and 7 percent of white children.[21] Nationwide, African American children are twice as likely to be uninsured during an entire year than white children (14.5% versus 7.4%). One in five (21%) of Hispanic children had not been covered by any health insurance for the entire year.[22]

Insurance matters: Although there are numerous barriers to access to high quality health care for children of color, it will be impossible to eliminate disparities without first ensuring that all children have health insurance. Among the reasons for high uninsurance rates among racial and ethnic minority groups are that minorities have experienced disproportionate declines in employment-based health care coverage because of higher unemployment rates, lower-paying jobs, and immigration status. And, even when parents in lower-paying jobs have employer-based health insurance, dependent care is often not available at an affordable cost to the family.[23]

Because of more limited access to employer-sponsored insurance, children of color are overrepresented in public health insurance programs, including Michigan's Medicaid and MIChild programs. These public programs are effective in improving access to appropriate health care. Compared to uninsured children, children covered by Medicaid are much more likely to have a usual source of care, are less likely to postpone health care, and are 26 percent more likely to have had a well-child visit.[24]

Insurance does not guarantee access. Even when insured, children from racial and ethnic minorities tend to have less access to health care and receive lower quality care than non-minorities.[25] For example, white children, regardless of insurance status, see physicians at twice the rate of minority children.[26]

Because pregnant women and children of color are disproportionately dependent on publicly-funded insurance, they face many of the access issues inherent to those systems. For example:

- Only 72 percent of women insured by Medicaid in Michigan started prenatal care in the first trimester, compared to 91 percent of those privately insured.[27]
- The infants born to mothers insured by Medicaid are almost twice as likely to be low-weight (10.4% for Medicaid compared to 5.6% for privately insured women).
- Only half of the children insured by Medicaid or MIChild usually receive care in a doctor's office, compared to 80 percent of children who are privately insured.[28]
- Children insured by Medicaid or MIChild are more than twice as likely to have unmet medical needs, and particularly dental care needs.[29]

The barriers to access are numerous, including:

- an inadequate number of providers and specialists accepting Medicaid patients in under-served areas, including dentists;
- providers unwilling to accept Medicaid-insured children as patients because of inadequate Medicaid reimbursement rates;
- practical problems for families such as transportation, inflexible work schedules, child care and language barriers; and
- copayments and premiums that are a barrier for low-income families.

Michigan has made the health needs of low-income children a high priority, but more needs to be done to reach children of color. The percentage of uninsured children is lower in Michigan than the national average, and is one of the lowest in the Midwestern region.[30] Michigan's primary public insurance program, the Medicaid program, was augmented in 1999 by the new federal State Children's Health Insurance Program (SCHIP), know in Michigan as MIChild.

There are a number of new state initiatives that hold the promise of reducing the health disparities experienced by children of color in Michigan:

- The Governor has appointed Michigan's first Surgeon General, Kimberlydawn Wisdom, whose job it is to provide leadership for moving Michigan toward a state of good health. The Surgeon General has established four strategic

priority areas for the state including the elimination of racial and ethnic health disparities.

- The Governor has established the Great Start Initiative that is led by the Children's Action Network and a new Children's Cabinet. The charge is to coordinate and align child and family programs and services across state agencies, including a shared policy agenda that promotes health, social and emotional development, and school readiness. As part of this initiative, the Michigan Department of Community Health (MDCH), the Family Independence Agency (FIA) the Michigan Department of Education and a range of other partners are collaborating on an Early Childhood Comprehensive Systems Planning Project that is developing strategies for a comprehensive system of care for children ages 0-5.
- The 2005 Michigan Title V Maternal and Child Health Block Grant lists the reduction in racial disparities in infant mortality, maternal deaths, low birth-weight, pre-term births and breast feeding rates among the top 10 priorities for the MDCH. A MDCH work group has been established to identify strategies to reduce racial and ethnic disparities.

In addition to the state's Medicaid and MIChild programs, Michigan has a range of public maternal and child health programs that address the needs of pregnant women and children, including some that specifically target children of color. The programs include Fetal Infant Mortality Review teams, maternal and infant support services, adolescent health services, childhood lead poisoning prevention programs, the Office of Minority Health, Healthy Start programs, the Michigan Teen Outreach Program, and Nurse Family Partnerships (a project in four communities with high African American infant mortality rates).

While many of these programs are critical components of the state's health system for children, they are often underfunded, implemented on a pilot basis, and vulnerable during budget cuts. For example, Michigan's Maternal and Infant Health Advocacy program that reached out to high-risk pregnant women who were not in prenatal care was eliminated in January 2003 by a budget-cutting Executive Order. Other health prevention programs that have been cut include local violence prevention initiatives, and injury prevention or SAFE KIDS coalitions.

The first step in improving the health of Michigan's children of color is to make sure all children are insured.

There are two major publicly-funded health insurance programs for low-income children in Michigan:

- the **Medicaid** program that serves pregnant women and infants with incomes of up to 185 percent of poverty, and children between the ages of 1 and 18 with incomes of up to 150 percent of poverty; and
- the **MIChild** program, that provides insurance to children in families with incomes of up to 200 percent of poverty who are not eligible for Medicaid.

In addition, Michigan has a program specifically for children with special health care needs known as Children's Special Health Care Services (CSHCS). The CSHCS program is for children (through age 20) with serious, chronic health problems requiring special health care services. The services covered include specialty care, family support, and coordinated community-based services. There are no fees for families whose income is at or below 250 percent of poverty, and other eligible families can participate on a sliding fee scale.

Medicaid: In June of 2003, there were a total of 740,362 children under the age of 19 enrolled in the Michigan's Medicaid program–approximately 29 percent of all the children in the state. The number of the state's children insured by Medicaid has continued to grow from 546,599 in December of 1997, to 740,362 in June of 2003–a 35 percent increase in less than five years.

Medicaid is the largest children's health program in the country, and provides coverage for low-income families and individuals, including families with children and preg-

nant women. Medicaid covers a wide range of diagnostic and health services for low-income pregnant women and children including regular checkups, immunizations, emergency care, dental care, pharmacy, prenatal care and delivery, vision and hearing, and mental health and substance abuse services.

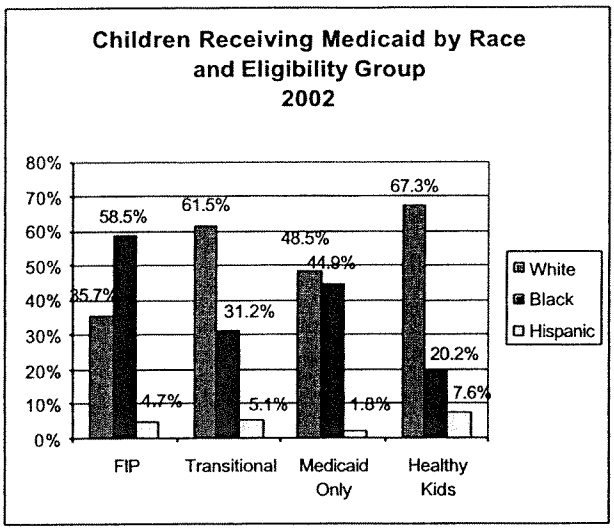
There are five major groups of children that are eligible for Medicaid in Michigan, including:

- children receiving SSI or who are blind or disabled;
- children who receive Medicaid only (no other assistance);
- children whose families receive income assistance through the Family Independence Program;
- children whose parents have moved from welfare to work in the last year and are receiving "transitional" Medicaid; and
- children enrolled in the "Healthy Kids" program– the Medicaid program covering low-income children whose parents do not receive income assistance.

The two largest groups of eligible children are those from low-income working families who qualify for the Healthy Kids program, and those whose parents are making the transition from welfare to work . With welfare reform, an increasingly small percentage of the children eligible for Medicaid are in families receiving income assistance.

African American children are disproportionately reliant on Medicaid, and are more likely to be eligible because their families rely on public cash assistance (through the Family Independence Program or FIP). Nearly 60 percent of the children receiving both Medicaid and FIP are African American. By contrast, only 11 percent of children eligible for the Healthy Kids Program are African American.

The cost of the state's Medicaid program has grown more than 40 percent since fiscal year 2000 in response to rising caseloads and health care costs. However, the vast majority of Medicaid costs are related to serving the elderly and the disabled. While 60 percent of those



insured by Medicaid are children, they account for less than 20 percent of all Medicaid expenditures in the state. It costs Michigan just $938 per year, on average, for each Medicaid eligible child, compared to the average cost per adult Medicaid enrollee of $4,785.[31]

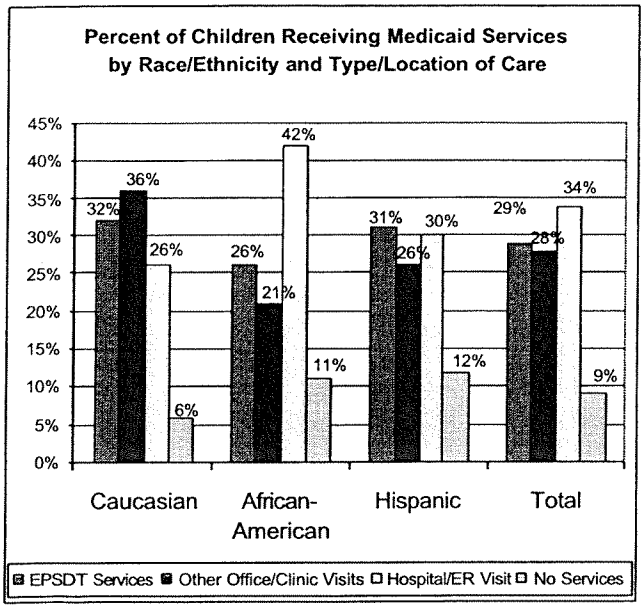
Maternal and Infant Support Services:

Maternal and Infant Support Services programs (MSS/ISS) are Medicaid-funded, in-home services provided to pregnant women and new mothers to help reduce infant mortality and improve birth outcomes. Because racial disparities in birth outcomes are so dramatic, these targeted services have the potential of reducing disparities for low-income and minority infants.

In 2003, the Michigan Legislature directed the MDCH to develop incentives for managed care providers to better utilize MSS/ISS services. In response, the MDCH has begun to study the MSS/ISS programs to determine which women are using them, the costs of services, and outcomes. In addition, the MDCH is working with a broader work group to improve communications with health care providers, and to design a process for WIC providers to refer pregnant women to MSS.

The Early Periodic Screening Diagnosis and Treatment Program (EPSDT):

One of the major benefits for children enrolled in the



Source: Michigan 2001 External Quality Review EPSDT Study.

Medicaid program is the Early Periodic Screening, Diagnosis and Treatment (EPSDT) program that entitles children to a comprehensive package of preventive health services. Under federal law, Michigan is required to screen Medicaid-eligible children for a range of health and developmental problems, and provide any necessary services. The screenings include basic well-child exams; vision, hearing and dental screenings; developmental and behavioral assessments; a review of immunization status; basic blood testing and urinalysis; and lead testing. Further, states are required to provide guidance to families related to injury and violence prevention, nutrition, growth and development.

Unfortunately, although there are improvements in EPSDT screening and service rates, the program has not yet met its promise of providing comprehensive preventive care to all Medicaid-eligible children, as the percentage of children receiving all required EPSDT services remains relatively low, particularly among school-age children and teenagers.

In 2001, of the total number of Medicaid-eligible children receiving any EPSDT services, 63 percent received a comprehensive EPSDT screening. Comprehensive screening rates were highest for infants and toddlers (90%) and lowest for school-age children (42% for children ages 7 to 12).[32] African American, Hispanic, and urban children were less likely than other children to receive EPSDT services, with minority adolescents least likely to receive services.

Further, children of color are substantially more likely to receive health care in emergency rooms or other settings where prevention services are typically not provided.[33] The 2001 External Quality Review of Michigan's EPSDT program found that 42 percent of African American children receiving Medicaid received care in a hospital or emergency visit, compared to 26 percent of white children.

One major concern is the low rate of testing for lead poisoning. If undetected and untreated, lead poisoning can result in brain damage, mental retardation, learning disabilities, behavior problems, anemia, liver and kidney damage, developmental delay, hyperactivity, and in extreme cases, death. Young children are most at-risk of lead poisoning because their brains are developing so rapidly, and they are more likely to expose themselves by putting contaminated items and hands in their mouths.

The EPSDT program requires that all young children insured by Medicaid be screened at 12 months and 24 months of age. In 2001, only 30 percent of children between the ages of 0 and 2 in Medicaid managed care plans were tested for lead poisoning; 20 percent of those in fee-for service arrangements were tested.[34]

In 2003, the Michigan Legislature directed the MDCH to develop and implement a plan to improve access to health screening services under the EPSDT program. In response, the MDCH created a collaborative EPSDT work group that includes representatives from public health, Medicaid health plans, universities and advocacy organizations. The work group held focus groups with parents and Medicaid providers to identify barriers to increased EPSDT screening rates, developed educational materials for parents and clinicians, and is running pilot programs to test a case management model, and gather information about barriers to well-child care for Medicaid beneficiaries.

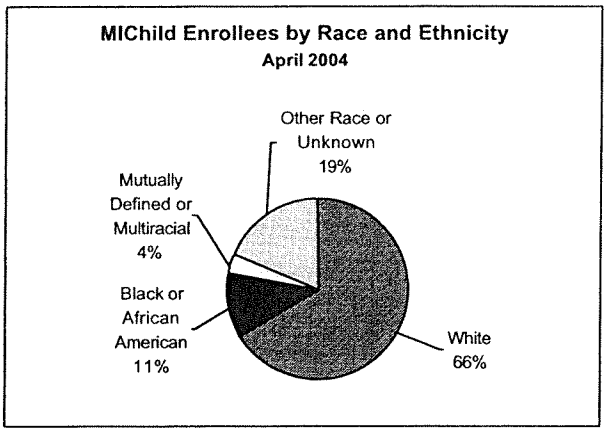
MIChild: MIChild is a health insurance program for children in low-income working families in Michigan. Congress created the State Children's Health Insurance Program (SCHIP) in 1997 to expand health coverage among children in low-income families. Michigan launched its SCHIP program—MIChild—statewide in 1998. Since that time, more than 107,000 children have received health insurance through the MIChild program, and current monthly enrollment in the program is nearly 35,000 statewide.[35]

MIChild covers children with family incomes of up to 200 percent of poverty who are not eligible for Medicaid. MIChild is modeled on private insurance and is provided through health care and dental plans throughout Michigan. Most (90 percent) of the children in MIChild are served by Blue Cross/Blue Shield of Michigan. Mental health and substance abuse services are provided by local Community Mental Health Services Plans and Substance Abuse Coordinating Agencies.

Two-thirds of the children enrolled in MIChild are white. African American children represent 11 percent of the children insured. The largest group of children served are school-age, between the ages of 5 and 14.

With the launching of the MIChild program, Michigan made a number of changes in the way applications for assistance are handled that are of benefit to low-income and minority children and families including:

- a joint MIChild and Medicaid application that allows the state to screen for eligibility for both programs at the same time;
- the elimination of the requirement for a face-to-face interview to determine eligibility;
- the elimination of an asset test;
- on-line applications;
- policies that allow eligibility to be renewed every twelve months, as well as continuous eligibility for Medicaid and MIChild for that period, regardless of family changes; and
- a policy that allows applicants to declare their income, without requiring verification.



Michigan has made significant efforts to enroll children in MIChild. And, because a high percentage of the children applying for MIChild are eligible for Medicaid, the program has served as an important outreach mechanism for the state's Medicaid program. For every child enrolled in MIChild, approximately two are transferred to Medicaid. Since 1998, nearly 240,000 children who applied for MIChild were transferred to the Medicaid Healthy Kids Program.[36]

Among the outreach efforts undertaken in Michigan with the launching of MIChild were:

- a statewide media campaign;
- resources for local human services collaborative bodies to develop MIChild outreach and marketing plans for their counties;
- a Blue Cross and Blue Shield of Michigan "Seek-Find-Enroll" initiative that fostered collaboration among nonprofit community organizations in 13 Michigan communities;
- a Robert Wood Johnson-funded "Covering Michigan Kids and Families" project that focused on Detroit, Muskegon and Marquette; and
- per capita bonus payments through local public health departments to organizations enrolling children.

Despite these outreach efforts, too many children in low-income working families, including many children of color, are needlessly uninsured because they are eligible for MIChild or Medicaid. Making matters worse, during

recent budget cuts, funding for outreach was reduced, including payments to local health departments and community organizations that help enroll children.

Across the state, half of all Michigan residents are not familiar with MIChild, and many others know little about eligibility or services under the program, indicating that much more needs to be done to promote MIChild.[37] Evaluations of outreach efforts show that strategies employed effectively in one community do not necessarily work with even the same ethnic population in another community within the state, and consequently outreach must be tailored community-by-community. Given the relatively low percentage of children enrolled in MIChild from racial and ethnic minority groups, outreach efforts targeted to children of color are needed.

What are the next steps in creating equal treatment for all Michigan children?

The diversity of Michigan is a great strength, but current racial and ethnic disparities in access to health care and health status present an enormous and critical challenge to state policymakers. The causes of health disparities are complex, and there will be no single easy "fix". Access to comprehensive and high quality health care is the base, but alone it will not completely eliminate disparities. The answers lie in public health, social services, economic, education and environmental policy.

1. *Policymakers and the public must become better informed about health disparities in Michigan.* There is insufficient data collected or reported on disparities in health outcomes for children, or importantly, on the antecedents to those disparities. The availability of sufficient data on racial and ethnic communities and children is necessary if Michigan is to craft effective strategies to level the playing field and measure progress toward eliminating health disparities. What we do not understand, we cannot fix. The Governor should establish a racial and ethnic data group to assess current data, determine data needs, and establish culturally appropriate methods for collecting data. Information collected should be disseminated broadly to policymakers, communities and the media.

2. *A broad-based Minority Health Task Force should be established to spearhead state efforts to reduce racial and ethnic disparities in children's health.* Because the causes of health disparities in children are complex, collaboration will be required. The state's strategy to address health disparities in children should involve legislators, state administrators, health care providers, the public health community, advocates, community-based organizations, and communities of color. Interdepartmental collaboration will be critical to address the environmental, poverty, transportation, housing and other issues that affect the health of poor children and children of color, as well as their access to health care.

3. *A strategy must be developed to ensure that every eligible child is enrolled in Medicaid or MIChild, with a focus on reaching out to children of color.* Many children and teenagers who are eligible for publicly subsidized health insurance are not enrolled. The Urban Institute found that there are nearly 225,000 uninsured children in Michigan, or approximately 8 percent of all children. Of those, over 70 percent are uninsured even though they are eligible for Medicaid or MIChild.[38] Michigan has done an admirable job of reducing administrative barriers to enrollment in the MIChild program, and wherever possible, these policies–including presumptive eligibility—should be extended to the Medicaid program to ensure that every possible barrier to coverage is eliminated.

Unfortunately, despite successful public and private investments in outreach early in the implementation of MIChild, state funding for MIChild and Medicaid outreach was cut. Michigan should restore and expand funding for outreach for Medicaid and MIChild, with a specific focus on underserved communities, including communities of color. More aggressive outreach at the state and local levels is required to reduce the number of "needlessly uninsured" children.

4. *Prevention and health promotion services targeted to children of color must be expanded.* Children from racial and ethnic minorities are more likely to suffer from, and even die from, preventable and treatable illnesses. Existing and new resources for health promotion and

prevention should be allocated in ways that strategically target the children most at-risk, including children of color.

MSS/ISS: The MDCH has undertaken a number of efforts to ensure expanded access to MSS/ISS services, but given the dramatic racial and ethnic disparities in access to prenatal care, low birth-weight, and infant mortality, a expanded focus on outreach to African American and other minority mothers is required.

EPSDT: Despite expanded efforts by the Michigan Department of Community Health, many children, and particularly children of color, are not receiving all the prevention services required under federal law. Michigan is involved in efforts to expand EPSDT screening rates, and this work should be continued and intensified to include a focus on the specific barriers faced by children and families of color. Included should be increased efforts to educate Medicaid providers and beneficiaries about the importance of EPSDT, with a focus on Hispanic and African American children. Also needed is a stronger emphasis on data collection so a true picture of children's access to preventive care can be drawn.

Health Promotion: Health promotion and prevention programs funded through the Healthy Michigan Fund and other funding sources should be reviewed to ensure that resources are coordinated to best meet the needs of minority children who are most likely to be at-risk. Among the programs that should be reviewed are lead poisoning prevention, violence prevention, childhood injury prevention, pregnancy prevention, school health education services and physical fitness/obesity prevention. One particular challenge is the need to assess barriers for children of color, and to develop culturally appropriate health promotion messages targeted to a variety of racial and ethnic groups. This work can only be done if there is real collaboration among health departments, community-based organizations, and minority communities.

One promising development is the recent inclusion in the fiscal year 2005 budget of expanded Healthy Michigan Fund resources for infant mortality ($1 million); lead poisoning prevention ($1 million); physical fitness, nutrition and health ($900,000); local maternal and child health services ($246,000); migrant health services ($340,000); and minority health services ($900,000). These funds should be used to address unacceptable health disparities in Michigan, particularly as they affect the state's children.

One area of ongoing concern is the dearth of funding for violence prevention. Homicide remains the leading cause of death for African American males between the ages of 15 and 24, yet programs for violence reduction are scattered throughout the major state departments, and funding for community-based violence prevention programs has been cut. To address this unacceptable victimization of African American youths, Michigan must develop a comprehensive approach to youth violence prevention that includes early childhood services, early intervention services, after-school programs, and youth employment activities. To that end, Michigan has recently received a federal planning grant to develop a strategic plan to reduce violence among children and youths. The planning grant will address child maltreatment, suicide, school and community violence, bullying, and sexual violence.

5. *Fetal Infant Mortality Review (FIMR) teams should be expanded.* Michigan has the 3rd worst infant mortality rate in the nation, in large part because African American infants in this state are three times more likely to die during the first year of life than white infants. Local FIMR boards, of which there are now 13 in the state, are the best vehicle available to identify the causes of, and solutions to, disproportionate African American infant death rates. Local FIMR teams are reviewing infant deaths, identifying the causes of deaths, and establishing community teams to address the problems identified.

6. *School- and community-based adolescent health clinics in low-income communities should be expanded with a focus on the special needs of adolescents from racial and ethnic minority groups.* Many teenagers remain uninsured. Adolescents are less likely to have health insurance than other age groups, and even those with public insurance face barriers to care. Studies have shown that adolescents newly insured by SCHIP programs have had limited prior opportunities for pri-

vate preventive health care, and the most underserved are African American and Hispanic adolescents.[39] Adolescent health centers are designed to overcome barriers that hinder adolescents from getting needed comprehensive health care and services, including concerns about confidentiality, cultural barriers, language barriers and transportation.

In 2003, Michigan funded 22 clinical teen health centers, and 9 non-clinical centers (that did not deliver on-site primary care services). These centers served over 20,000 teens in 2003. Overall, two of every three youths served were African American. In the clinical centers, 49 percent were African American.**

The MDCH has received federal approval to use Medicaid funds to increase outreach through adolescent health centers and increase access to prevention services . In this expansion of adolescent health services, particular attention should be given to the special needs of adolescents from racial and ethnic minority groups.

7. *The MDCH should continue to use its purchasing power to ensure that health plans provide culturally competent prevention services*. Approximately 80 percent of Michigan children ensured by Medicaid are enrolled in a managed care plan. Michigan has a number of managed care contract provisions designed to improve access to culturally competent prevention services that must be monitored and strictly enforced, including:[40]

- Medicaid managed care providers are held contractually accountable for delivering health care services in a manner that focuses on health promotion and disease prevention.
- Medicaid managed care providers are obligated to provide a range of services, including well-child and EPSDT services, parenting and birthing classes, medically necessary weight reduction services, MSS/ISS services and outreach for pregnancy-related and well-child care.
- Managed care providers are required to reimburse adolescent health centers for services provided to Medicaid enrollees, even if there was no prior authorization.
- Managed care providers must ensure that they respond to the cultural, racial and linguistic needs of the Medicaid population, and that services are provided without regard to race, color, national origin or ancestry.
- Managed care providers are encouraged to work closely with local public and private community-based organizations to address health care issues, and to ensure access through community-based "safe harbors" that address local cultural standards and practices.

The MDCH retains a pool of approximately $4 million each year for bonus payments to health plans that meet performance standards in such areas as the provision of EPSDT services, early prenatal care, well child visits and immunizations. Enforcement of contractual obligations and provider incentives are important mechanisms for ensuring better access to services for low-income children and children of color.

8. *The Michigan Legislature must address the structural revenue problems that threaten Michigan's ability to provide basic health care to low-income and minority pregnant women, infants and children.* Because children of color are disproportionately reliant on publicly-funded health insurance including Medicaid and MIChild, they have the most to lose if eligibility or benefits must be reduced because of inadequate revenues. Since fiscal year 2002, more than $700 million in gross reductions have been made in the Medicaid budget including eligibility restrictions, limitations in the services covered by Medicaid, and reductions in provider reimbursements.[41]

As Medicaid caseloads have risen in Michigan, the strain on the state budget has increased. Unfortunately, cuts in Medicaid services and eligibility have high costs that are both human and fiscal. Children who do not receive basic health care are more likely to suffer long-term chronic illnesses that cost more to treat in the long run and reduce their chances of future success in school, the workforce and life. Further, a failure to recognize Medicaid providers' costs and reimburse them appropriately can result in fewer providers accepting Medicaid pa-

tients, further restricting children's access to care. Michigan must establish a fair and adequate tax structure that ensures that low-income children and children of color have access to health care.

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